DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH

NOTICE OF FINAL RULEMAKING

The Director of the Department of Health, pursuant to the authority set forth in An Act to enable the District of Columbia to receive federal financial assistance under Title XIX of the Social Security Act for a Medical Assistance program, and for other purposes, approved December 27, 1967 (81 Stat. 744; D.C. Official Code, § 1-307.02), Reorganization Plan No. 4 of 1996, and Mayor's Order 97-42, dated February 18, 1997, hereby gives notice of the adoption of a new Chapter 42 of Title 29 of the District of Columbia Municipal Regulations (DCMR) entitled, "Home and Community-Based Waiver Services for Persons who are Elderly and Individuals with Physical Disabilities."

These rules establish standards governing reimbursement by the District of Columbia Medicaid Program for the provision of home and community-based waiver services for persons who are elderly and individuals with physical disabilities provided by home care and home health agencies, social service agencies, or community-based organizations licensed to do business in the District of Columbia. These rules are being adopted to enhance the range of existing health services for low income senior citizens within the District of Columbia 65 years and older and to expand the range of health care services for low income individuals with physical disabilities eighteen (18) years or older.

A notice of emergency and proposed rulemaking was published in the *D.C. Register* on June 6, 2003 (50 DCR 4414). Comments on the proposed rules were received. Sections 4218.8(b) and 4217.7(f) were deleted in response to comments received. Otherwise, there are no changes to the substance of the proposed rules.

These rules shall become effective one day after publication of this notice in the *D.C. Register.*

CHAPTER 42

HOME AND COMMUNITY-BASED WAIVER SERVICES FOR PERSONS WHO ARE ELDERLY AND INDIVIDUALS WITH PHYSICAL DISABILITIES

4200 GENERAL PROVISIONS: IDENTIFICATION OF SERVICES; AUTHORITY OF OPERATION; TARGETING RESTRICTIONS.

4200.1 The following home and community-based waiver services are included in this chapter, consistent with the regulations set forth herein:

(a) Case management services;

(b) Personal care aide services;

(c) Personal emergency response system services;

(d) Respite services;

(e) Homemaker services;

(f) Chore aide services; and

(g) Environmental accessibility adaptations services.

4200.2 The waiver services described in this chapter shall be operated or administered directly by the Medical Assistance Administration (MAA), D.C. Department of Health.

4200.3 The home- and community-based waiver services described in this chapter are furnished only to individuals who:

(a) Have had a determination by the MAA that the recipient is likely to require the care furnished in a nursing facility under Medicaid;

(b) Require assistance with activities of daily living;

(c) Agree to participate in the waiver program by signing a Beneficiary Freedom of Choice form;

(d) Are 65 or older;

(e) Are adults, age 18 and older, with physical disabilities;

(f) Are not inpatients of a hospital, nursing facility or intermediate care facility for the mentally retarded; and

(g) Are Medicaid eligible with a maximum monthly income of three hundred percent (300%) of Supplemental Security Income (SSI).

4201 CASE MANAGEMENT SERVICES REQUIRED

4201.1 As a condition of waiver participation in the home- and community-based waiver services program, each recipient or applicant must receive case management services for each service(s) provided.

4201.2 No recipient shall receive case management services unless the recipient or an authorized representative of the recipient signs the "Beneficiary Freedom of Choice Form" provided by the recipient's case manager to elect to receive home and community-based waiver services.

4202 WRITTEN INDIVIDUALIZED SERVICES PLAN REQUIRED

4202.1 Home- and community based waiver services must be provided under a written individualized services plan (ISP) for each recipient based on an assessment of the recipient's health and welfare needs.

4202.2 An ISP must be developed for each recipient prior to the initiation and provision of any waiver services and must be pre-authorized by the MAA.

4202.3 An ISP shall be a specific plan for delivering services to the waiver recipient.

4202.4 An ISP shall be updated and revised quarterly, at a minimum.

4202.5 Each ISP for each waiver recipient shall contain, at a minimum:

(a) A statement of goals and objectives for meeting identified needs;

(b) A detailed description of the methods or approaches to be used in addressing identified needs;

(c) An assessment of the recipient's need for follow-up care visits;

(d) The number of units of services;

(e) The frequency and duration of each service;

(f) Documentation that the recipient is Medicaid eligible;

(g) Documentation that the recipient has a nursing facility level of care; and

(h) A signed "Waiver Beneficiary Freedom of Choice Form," provided by the recipient's case manager.

4203 INITIATING, CHANGING, OR TERMINATING ANY APPROVED SERVICE

4203.1 Only the case manager is authorized to admit, request a change in services, or discharge a recipient from the waiver services program.

4203.2 Each provider of waiver services shall receive approval from the case manager prior to initiating, changing, adding, or terminating any approved waiver service. The case manager shall forward a copy of the Change Request or Discharge Summary to the MAA and to all other providers.

4204 NON-ENGLISH SPEAKING RECIPIENTS

4204.1 Each provider of waiver services shall establish a plan to adequately provide service(s) to non-English speaking recipients. The provider shall identify the necessary resources and individuals in order to implement the plan. Identification of necessary resources may include referring the recipient to another service provider agency or business with staff that is able to meet the particular language need of the recipient.

4204.2 When a referral of a non-English speaking recipient is made, the provider shall communicate (by telephone within twenty-four (24) hours of the referral) the request to the appropriate case management service provider for approval. A written verification of the referral shall be sent to the case manager within forty-eight (48) hours of the referral.

4205 RECORDS AND CONFIDENTIALITY OF INFORMATION: GENERAL

4205.1 Each provider of waiver services shall establish and implement a plan to protect the privacy and confidentiality of a recipient's records.

4205.2 The disclosure of treatment information by a provider of waiver services is subject to all the provisions of applicable District and Federal laws, for the purpose of confidentiality of information.

4205.3 Each provider of waiver services shall maintain comprehensive records of the waiver services provided to each recipient and shall maintain each record for a period of not less than six (6) years.

4205.4 Each recipient's record shall include, but is not limited to, the following information:

(a) General information including each recipient's name, Medicaid identification number, address, telephone number, age, sex, name and telephone number of emergency contact person, physician's name, address, and telephone number;

(b) A record of a Bill of Rights and Responsibilities;

(c) The initial and annual ISP developed by the case manager and approved by designated MAA staff;

(d) A copy of the initial and annual ISP for other service providers as approved by the case manager;

(e) A record of all service(s) provided, including description and dates of services rendered;

(f) A record of staff person(s) providing the service(s);

(g) A copy of the initial and annual level of care determinations;

(h) A record of the initial and annual Beneficiary Freedom of Choice;

(i) A record of all monthly in-home site visits and telephone contacts;

(j) A record of all monthly system checks and telephone contacts;

(k) A record of the initial and annual Pre-Admission Screening and Resident Review (PASRR) for mental illness or mental retardation and Psychiatric Evaluation, as necessary;

(l) A record of all quarterly reviews and narrative notes;

(m) A record of the recipient's initial and annual health history;

(n) A record of all prior authorizations for services;

(o) A record of all requests for change in services;

(p) A discharge summary, if applicable; and

(q) Any other records necessary to demonstrate compliance with all rules, regulations, requirements, guidelines, and standards for the implementation and administration of this waiver.

4206 ACCESS TO RECORDS

4206.1 Each provider of waiver services shall allow access to a recipient's records during announced or unannounced audits or reviews by designated MAA staff and federal representatives and as set forth in §§ 4237.3 and 4237.4 of this chapter.

4207 REIMBURSEMENT: GENERAL

4207.1 The MAA shall not reimburse any provider of waiver services who:

(a) Fails to comply with any applicable regulation in this chapter;

(b) Fails to comply with all applicable federal and District of Columbia laws, rules, and regulations; and

(c) Fails to comply with all applicable transmittals, rules, manuals and other requirements of the MAA.

4207.2 Each provider of waiver services shall agree to accept as payment in full the amount determined by MAA as reimbursement for the authorized waiver services provided to recipients.

4207.3 Each provider shall agree to bill any and all known third-party payers prior to billing Medicaid.

4208 REIMBURSEMENT RATES: CASE MANAGEMENT SERVICES

4208.1 Case management services shall be reimbursed at the following levels:

(a) For initial assessments, five hundred dollars ($500.00) shall be reimbursed by M AA;

(b) For monthly assessments, one hundred and twenty-five dollars ($125.00) shall be reimbursed by the MAA;

(c) For annual re-assessments, two hundred and twenty-five dollars ($225.00) shall be reimbursed by the MAA.

4209 REIMBURSEMENT RATES: PERSONAL CARE AIDE SERVICES

4209.1 A home care agency seeking reimbursement for personal care aide services shall meet the conditions of participation for home health agencies set forth in 42 CFR 484, and shall comply with the requirements set forth in the Health-Care and Community Residence Facility Act, Hospice, and Home-Care Licensure Act of 1983, effective Feb. 24, 1984 (D.C. Law 5-48; D.C. Official Code § 44-501 *et seq.*).

4209.2 Each provider shall be reimbursed thirteen dollars and fifty cents ($13.50) per hour for services rendered by a Personal Care Aide.

4209.3 A unit of service for Personal Care Aide services shall be one (1) hour spent performing the allowable tasks.

4209.4 Reimbursement for personal care aide services shall not exceed sixteen (16) hours of service per day per recipient.

4209.5 A provider of waiver services shall not bill the recipient or any member of the recipient's family for personal care aide services.

4209.6 The MAA may limit or deny services, if the cost of the services in addition to other home care services exceeds the estimated cost of institutional care.

4210 REIMBURSEMENT RATES: PERSONAL EMERGENCY RESPONSE SERVICES

4210.1 The reimbursement rate for Personal Emergency Response Services shall be forty dollars ($40.00) for one (1) installation and twenty-eight dollars and fifty cents ($28.50) per month for the rental fee.

4211 REIMBURSEMENT RATES: RESPITE SERVICES

4211.1 The reimbursement rate for respite services is thirteen dollars and fifty cents ($13.50) per hour for individuals needing one (1) to seventeen (17) hours per day, and a flat rate of two hundred dollars ($200.00) per day for individuals needing eighteen (18) to twenty-four (24) hours per day.

4211.2 The MAA shall not reimburse a provider of respite services who is the waiver recipient's spouse, parent of a minor child or, other legally responsible relative.

4211.3 MAA shall not reimburse for the cost of room and board except when provided as part of respite care furnished in a facility approved by the District of Columbia that is not a private residence.

4212 REIMBURSEMENT RATES: HOMEMAKER SERVICES

4212.1 The reimbursement rate for homemaker services shall be $10.50 per billable hour.

4213 REIMBURSEMENT RATES: CHORE AIDE SERVICES

4213.1 The reimbursement rate for chore aide services shall be fifteen dollars ($15.00) per hour.

4213.2 Reimbursement for chore aide services shall not be claimed by any home care, home health agency, or business that provide services in residences where another party is otherwise responsible for the provision of the services, such as group home providers.

4213.3 The MAA shall not reimburse a home care, home health agency, or business that is the waiver recipient's spouse, parent of a minor recipient or other legally responsible relative.

4213.4 Chore services shall not be reimbursed by the MAA unless the agency provides documentation of pre- and post-cleaning activities.

4214 REIMBURSEMENT RATES: ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS SERVICES

4214.1 Environmental accessibility adaptations services shall be reimbursed in accordance with the applicable requirements set forth in §§ 4233 through 4234 of this chapter.

4215 PROVIDER REQUIREMENTS: GENERAL

4215.1 Each provider approved to provide one or more waiver services shall meet the following minimum requirements:

(a) Have a current provider agreement on file with the MAA before providing any waiver services; and

(b) Be licensed to do business in the District of Columbia.

4215.2 Each provider of waiver services shall demonstrate a comprehensive knowledge and understanding of the MAA Program including:

(a) Knowledge of State Plan services and limitations thereof;

(b) Knowledge of linkages to community resources (legal, housing, rental, energy, food, transportation, and other medical and social assistance) and the methods of accessing these resources; and

(c) An understanding of the relationship between State Plan and waiver services, where applicable.

4215.3 Each provider of two (2) or more waiver services to the same recipient shall coordinate supervisory visits in order to avoid duplication of services and unnecessary cost to the District.

4215.4 Each provider of waiver services shall notify the District of any and all recipients who are hospitalized or who have had their waiver services placed "On-Hold" for any reason.

4215.5 Each provider of waiver services shall demonstrate a service history and current capacity to provide services to recipients who reside in all four (4) quadrants of the District of Columbia, and to assist recipients in accessing those services.

4215.6 Each provider of waiver services shall demonstrate a service history and current capacity to assist recipients in accessing services provided through the District of Columbia Office on Aging or other agencies serving the elderly and individuals with physical disabilities.

4215.7 Each provider of waiver services shall require and thoroughly check at least two (2) references on all staff that enter the home of a waiver recipient.

4215.8 Each provider of waiver services shall obtain a criminal background check on each direct care employee to be sent into a recipient's home or permanent place of residence.

4215.9 No employee of a provider of waiver services who has been convicted of a felony, a crime involving abuse, neglect, or violence against the person of another, or crime involving theft or larceny under Federal or state law shall provide service(s) to a recipient.

4215.10 Each provider of waiver services shall conduct a performance evaluation of each case manager after the first three (3) months of employment and annually thereafter.

4215.11 Each provider of waiver services that provides staff with hands-on responsibilities (for example, staff that has direct contact with recipient's bodily fluids) shall ensure that the service provider is trained in universal precautions prior to the provision of any service. Universal precautions training shall be included as part of one of the annual continuing education classes.

Documentation of universal precautions training shall be maintained in the employee's file for a period of not less than six (6) years.

4215.12 Each provider of waiver services shall establish and implement a process to ensure that each recipient has:

(a) Been informed of and given freedom of choice in the selection of all qualified providers of services;

(b) Been informed of his or her rights and responsibilities under the waiver program; and

(c) Exercised his or her choice and signed a "Waiver Beneficiary Freedom of Choice " form, either personally or through an authorized representative.

4216 SPECIFIC PROVIDER REQUIREMENTS: CASE MANAGEMENT AND RELATED WAIVER SERVICES

4216.1 Each individual providing case management and related waiver services shall meet the following requirements:

(a) Be at least eighteen (18) years of age;

(b) Be a United States citizen or alien who is lawfully authorized to work in the United States;

(c) Provide proof of the supporting documents for the Immigration and Naturalizations Services Form I-9 requirements;

(d) Meet the minimum standards for providing case management services; personal care aide services; personal emergency response system services; respite services; homemaker services; chore aide services; and environmental accessibility adaptations services.

(e) Be able to read and write in English;

(f) Be acceptable to the recipient;

(g) Be free of active tuberculosis as confirmed by an annual purified protein derivative (PPD) skin test or chest x-ray;

(h) Be free of active tuberculosis and any other communicable disease; and

(i) Provide evidence of acceptance or declination of the Hepatitis vaccine.

4216.2 Individuals conducting case management services shall meet one of the following requirements:

(a) Have a current appropriate licensure, and have a Masters degree in social work, psychology, counseling, rehabilitation, nursing, gerontology, or sociology and have at least one (1) year of experience working with the elderly or individuals with physical disabilities;

(b) Have a current appropriate licensure and have a Bachelors degree in social work, psychology, counseling, rehabilitation, nursing, gerontology, or sociology and have two (2) years of experience working with the elderly or individuals with physical disabilities; or

(c) Have a current license as a Registered Nurse (RN), and have an Associate degree in nursing, and at least three (3) years of experience working with the elderly and individuals with physical disabilities.

4216.3 Case management service providers shall not provide medical, financial, legal, or other service or advice for which they are not qualified or licensed to perform (except for referral to qualified individuals, agencies, or programs).

4216.4 Each case management service provider is responsible for conducting a comprehensive assessment of the recipient by using the assessment tool that is provided by the MAA.

4216.5 Each case management service provider shall conduct a comprehensive assessment within forty-eight (48) hours of receiving the wavier referral and prior to the development of the ISP.

4216.6 Each case management service provider shall complete the written assessment and ISP within forty-eight (48) working hours of conducting the comprehensive assessment.

4216.7 Each case management service provider shall include family members, friends of the recipient, and any other appropriate individual(s) in the initial recipient assessment and in the development and implementation of the ISP, as appropriate. The recipient or authorized representative shall have access to the ISP and shall be involved in the periodic review thereof.

4216.8 A case management service provider shall submit to the MAA the following documentation for review and approval within seven (7) working days of its receipt:

(a) Documentation that the recipient is Medicaid-eligible and include the Medicaid application and supporting documents;

(b) A signed "Waiver Beneficiary Freedom of Choice Form;"

(c) Documentation of a comprehensive assessment (Recipient Health History);

(d) Bill of Rights and Responsibilities; and

(e) Completed ISP for review and approval.

4216.9 It is the responsibility of the case management service provider to ensure that all other professional disciplines as identified for resolution of identified needs are incorporated into the ISP.

4216.10 Each case management service provider shall maintain, follow, and continually update a training and supervision program to make sure the case management staff person who is responsible for the provision of case management services is fully trained and familiar with the waiver policies and procedures.

4216.11 Each provider of case management services shall ensure that case management service providers are appropriately supervised and that the case management service provided is consistent with the recipient's ISP.

4217 PROGRAM SERVICES: CASE MANAGEMENT SERVICES

4217.1 A case management service provider shall conduct all case management services for waiver recipients.

4217.2 Case management services are ongoing activities and shall include the following:

(a) Conducting direct observation of the recipient;

(b) Conducting financial and functional eligibility screening, contact, or interaction with the recipient's authorized representative;

(c) Conducting a comprehensive assessment of the recipient's medical, social, and functional status to include obtainment of level of care determination and financial eligibility documentation;

(d) Assisting the recipient with identification and selection of approved and enrolled service providers subject to the recipient's choice;

(e) Assisting the recipient with securing necessary physician orders when required for the initiation of any service;

(f) Determining and developing the recipient's ISP in collaboration with an interdisciplinary team of professionals and including the recipient or authorized representative, family members, friends, providers of health related services, recipient's physician, and legal guardian, where appropriate, in establishment of the service plan;

(g) Presenting the ISP (including goals, service providers, frequency, and duration of services) to the recipient or representative for acceptance;

(h) Submitting the ISP to MAA for review and approval;

(i) Assisting the recipient with initiating service provision, confidentiality, and measuring the recipient's progress against the ISP; and providing telephone reassurance and friendly visiting to recipients as part of the case management program;

(j) Conducting a periodic (at least quarterly) review of the recipient's ISP;

(k) Assisting the recipient in gaining access to needed Medicaid-financed services and all other needed supports (for example, medical, financial, counseling, housing, adult day care, and personal assistance) that are necessary to maintain the recipient in the community;

(l) Coordinating all waiver services for the recipients so that services provided to recipients are delivered in a safe, timely, and cost effective manner; providing supportive counseling to the recipient and family as appropriate; and addressing and resolving identified problems;

(m) Coordinating and monitoring necessary and appropriate services in a timely manner (including twenty-four (24) hour crisis coverage) for the waiver recipient as specified in the recipient's ISP;

(n) Providing information about non-Medicaid programs and services for which the recipient might be eligible; referring the recipient to the proper service as necessary; and providing assistance to the recipient in gaining public benefits and linkages to community resources;

(o) Documenting monthly in-home visits and telephone contacts;

(p) Reviewing and approving the ISP of the direct care and other service providers in a timely manner, and maintaining copies in the recipient's record;

(q) Ensuring the provision of supplies and equipment for use in the recipient's care;

(r) Providing supportive counseling to the recipient and family, as appropriate;

(s) Ensuring the cost-effectiveness of the recommended waiver services;

(t) Coordinating multiple services or providers; and providing on-going assessment of the recipient's continued appropriateness for participation in the waiver;

(u) On-going monitoring of the implementation of ISP to ensure quality of care and service provisions;

(v) Ensuring that the recipient obtains annual (and as needed) level of care certification, and ensuring that the information is forwarded to MAA prior to the expiration of the current certification period;

(w) Documenting quarterly reviews that provide a synopsis of the recipient's care and outcomes within a defined period; and

(y) Maintaining records necessary to provide supportive documentation of all case management services provided.

4217.3 When conducting quarterly reviews, the case manager shall also include the following documentation as part of the complete synopsis of the recipient's care and outcomes for a defined period:

(a) Utilization of services;

(b) Communication with other providers regarding the recipient's goals and progress;

(c) Identification and resolution of problems; and

(d) Referrals or linkages to community resources.

4217.4 A case management aide shall assist the case manager in the implementation of the recipient's ISP.

4217.5 A case management aide shall conduct the following duties:

(a) Provide clerical support to the case manager; and

(b) Assist the case manager with contacting service providers and arranging for the provision of recipient services consistent with the approved ISP.

4217.6 Case management aides shall not conduct the following activities:

(a) Recipient's assessment;

(b) Development of the recipient's ISP; and

(c) In-home visitations.

4217.7 A unit of case management services for the recipient's initial assessment, ISP development, and service implementation shall be all activities that include the following:

(a) Obtaining a level of care determination;

(b) Obtaining the recipient's (or representative) agreement to participate in the waiver by completion of the Beneficiary Freedom of Choice form;

(c) Completing the comprehensive recipient assessment by completing and authenticating the Recipient Health History form;

(d) Developing the comprehensive ISP utilizing interdisciplinary team members, recipient or designee, family members, or a legal guardian;

(e) Presenting the completed ISP to the recipient or designee for acceptance of services;

(f) Submitting the ISP to the MAA for review and approval;

(g) Completing the Medicaid application and obtaining supporting documents;

(h) Assisting the recipient in the selection of service providers; and

(i) Ensuring the proper implementation and utilization of services.

4217.8 A unit of case management services for an annual re-assessment of the recipient shall be all activities associated with the initial assessment of the recipient in order to continue waiver and other needed services. The annual re-assessment shall occur prior to the expiration of the certification period in order to continue waiver services. Re-assessment activities shall also include the following:

(a) Re-determining eligibility and level of care of the recipient;

(b) Performing a re-assessment of the recipient's needs and goals; and

(c) Assessing progress in meeting established goals, as established in the ISP;

4217.9 A unit of case management services for recipient for monthly service coordination activities shall be all activities associated with general oversight of the recipient and all services being provided to the recipient. Included in this service unit are the following activities:

(a) Monthly (within thirty (30) days) in-home visits;

(b) Communicating and coordinating with service providers, as needed;

(c) Documenting all case management activities;

(d) Identifying and resolving problems or needs;

(e) Communicating with the District of Columbia MAA personnel, as needed; and

(f) Conducting all other activities related to the efficient administration of the waiver and maintaining the recipient in the community.

4218 RESPONSIBILITIES OF CASE MANAGERS

A case manager shall establish a specific written ISP for each recipient of waiver services and shall ensure, at a minimum, that the ISP is in accordance with the requirements of subsections §§ 4201 through 4204 of this chapter.

4218.1 Each case manager shall not have a recipient caseload greater than forty-five (45) persons (inclusive of Medicaid and non-Medicaid recipients) when the service provision is not supported by the services of a case management aide. In cases where the provision of case management services are supported by the services of a case management aide, the case management service provider shall not have a recipient caseload greater than fifty (50) persons (inclusive of Medicaid and non-Medicaid recipients).

4218.2 The case manager shall utilize uniform documentation forms as provided and directed by the MAA.

4218.3 The case manager shall ensure that all of the documents listed in § 4216.8 are submitted to the MAA for review and approval of services. The MAA shall approve or disapprove the ISP within seven (7) working days of its receipt.

4218.4 The case manager shall conduct a comprehensive reassessment of the recipient and ensure completion of all waiver documents listed in § 4216.8 on an annual

basis prior to expiration of the current certification period and submitting the waiver package to the MAA for review and approval.

4218.5 Following the approval of service from the MAA, the case manager shall follow-up promptly with the selected providers of services to ensure that all services are in place, and that the quantity and quality of services are sufficient to meet the identified needs of the recipient.

4218.6 The case manager shall ensure that the recipient is given free choice of all qualified providers of each service included in his or her written ISP.

4218.7 Each case manager who provides direct case management services is required to assist the recipient in accessing all necessary services that are available to the recipient and that are necessary to maintaining the recipient in the community whether they are Medicaid (State Plan) services, Medicaid (waiver) services, or non-Medicaid financed services.

4218.8 Each case manager shall attend training sessions as scheduled and required by the MAA in order to promote the efficient and effective delivery of Medicaid-financed services.

4218.9 Each case manager shall develop and implement a utilization review plan to ensure non-duplication of services being provided to the recipient. The utilization review plan shall also evaluate the appropriateness, efficiency, adequacy, and coordination of services with the objective of achieving the least costly, yet most appropriate delivery of waiver services.

4218.10 When conducting quarterly reviews, the case manager shall also include the following documentation as part of the complete synopsis of the recipient's care and outcomes for a defined period:

(a) Utilization of services;

(b) Communication with other providers regarding the recipient's goals and progress;

(c) Identification and resolution of problems; and

(d) Referrals or linkages to community resources.

4218.11 The case manager shall ensure that a home assessment is conducted (by a licensed physician or a licensed physical therapist) prior to ordering EAA service(s) on the ISP. The signed assessment form shall be submitted to the MAA with the ISP.

4218.12 Prior to initiating EAA services, the case manager shall obtain an evaluation from a Construction Analyst or Housing Inspector. The evaluation must substantiate that the home is in a condition that is structurally sound to accommodate each ordered service(s) and include any stipulation(s) or recommendation(s) on how the service(s) should be implemented.

4218.13 Each case manager shall develop (and be prepared to implement) twenty-four (24) hour emergency service(s), should the recipient so require.

4218.14 Each case manager shall approve requests for changes, additions, or termination of services utilizing the "Request for Change in Services" form, amending the ISP to reflect the requested changes, and submitting the change request and amended ISP to MAA for review and approval. Only the case manager shall admit, request a change in services, or discharge a recipient from the waiver program.

4218.15 The case manager may terminate waiver services when at least one (1) of the following conditions exist:

(a) The recipient no longer meets the financial eligibility criteria;

(b) The recipient expires;

(c) The recipient has moved out of the District of Columbia;

(d) The recipient's condition has improved, and the recipient no longer requires assistance with activities of daily living (ADL) and instrumental activities of daily living (IADL) as per the level of care criteria;

(e) The recipient (if competent to make decisions) requests termination of services;

(f) The recipient has been permanently placed in an institution;

(g) The recipient's certification period has ended and the recipient remains institutionalized;

(h) The recipient is unwilling to use available services and the multidisciplinary team is unable to propose a plan that is acceptable to the recipient; and

(i) The recipient's behavior poses a risk to the safety and well being of the provider staff.

4218.16 If the termination of services is based on §§ 4218.15(h) or 4218.15(i), the case manager shall provide the recipient or authorized representative with a written

thirty (30) day notice in advance of the date of termination that shall include but is not limited to the following:

(a) Decision to terminate the services;

(b) Reason for termination of services;

(c) Copy of waiver standards supporting the termination decision;

(d) Copy of the directory of other waiver providers; and

(e) Information on the recipient's right to a Fair Hearing and instructions for obtaining a Fair Hearing.

4218.17 If a recipient desires to transfer to another provider of services, the case manager shall assist the recipient or authorized representative in the selection of a new provider(s) and ensure a smooth and complete transfer of the recipient to the selected provider(s).

4218.18 If the behavior of a resident poses an immediate threat to the safety and well being of the provider staff, the case manager shall immediately suspend or terminate the recipient's services. Suspension of services shall not exceed thirty (30) days.

4218.19 Within seventy-two (72) hours of suspension, the case manager shall notify the recipient or authorized representative in writing of the following:

(a) Grounds for suspension; and

(b) The recipient's right to appeal the suspension.

4218.20 At the end of the suspension period, the case manager may re-instate or terminate the recipient's services.

4218.21 The recipient shall be provided with a notice of termination at least fifteen (15) days before the effective date of termination, if the decision is made to terminate the services.

4218.22 The case manager shall document monthly (within thirty (30) days) in-home visits and telephone contacts within the recipient's record.

4219 SPECIFIC PROVIDER REQUIREMENTS: PERSONAL CARE AIDE SERVICES

4219.1 The provision of personal care aide services shall be in support and furtherance of the following goals:

(a) To provide necessary hands-on personal care assistance with the activities of daily living in order to maintain a recipient in the home in a clean, sanitary, and safe condition; and

(b) To encourage home-based care as a preferred and cost-effective alternative to institutional care.

4219.2 A provider of personal care aide services may contract with a personnel staffing agency for staff to perform personal care aide services. Agreements between the Provider and a contractor for the provision of personal care services shall be in writing and shall comply with the conditions as stipulated in the agreement.

4220 SPECIFIC ELIGIBILITY REQUIREMENTS: PERSONAL CARE AIDE SERVICES

4220.1 Each recipient shall meet the following qualifications to receive personal care aide services reimbursed by the Medicaid waiver program:

(a) Each recipient shall require assistance with activities of daily living;

(b) The recipient shall meet criteria that address functional limitations in activities of daily living (ADLs) and instrumental activities of daily living (IADLs) as specified on Form-1728. The recipient shall:

(1) Require extensive assistance or total dependence in at least two (2) of the five (5) activities of daily living (ADLs) as listed on Form-1728; or

(2) Require supervision, limited assistance, extensive assistance, or total dependence in at least two (2) of the five (5) activities of daily living (ADLs) as listed on Form-1728; and

(3) Require supervision, limited assistance, extensive assistance, or total dependence in at least three (3) of the five (5) instrumental activities of daily living (IADLs) as listed on Form-1728.

4221 PERSONAL CARE AIDE (PCA): QUALIFICATIONS

4221.1 Each personal care aide PCA shall:

(a) Be at least 18 years of age;

(b) Be a citizen of the United States or an alien who is lawfully authorized to work in the United States by providing documentation to meet the Immigration and Naturalization Services Form I-9 requirements;

(c) Complete a home health aide training program that includes at least seventy-five (75) hours of classroom training with at least sixteen (16) hours devoted to supervised practical training and pass a competency evaluation for those services which the Personal care aide (PCA) is required to perform consistent with the requirements set forth in 42 CFR 484.36. Each PCA shall provide a copy of certificate and competency evaluations;

(d) Be certified in cardiopulmonary resuscitation ("CPR") and thereafter obtain CPR certification annually;

(e) Be able to read and write the English language at the fifth (5^{th}) grade level and carry out instructions and directions;

(f) Be able to recognize an emergency and be knowledgeable about emergency procedures;

(g) Be knowledgeable about infection control procedures;

(h) Be acceptable to the recipient and not be a spouse or parent of a minor recipient, or other legally responsible relative;

(i) Demonstrate annually following the Centers for Disease Control (CDC) guidelines that he or she is free from communicable disease as confirmed by a chest x-ray or by an annual Purified Protein Derivative (PPD) Skin Test or documentation from a physician stating that the person is free from communicable disease;

(j) Pass a criminal background check pursuant to the Health-Care Facility Unlicensed Personnel Criminal Background Check Act of 1998, effective April 20, 1999 (D.C. Law 12-238; D.C. official Code, § 44-551 *et seq.*); and

(k) Provide documentation of acceptance or declination of the Hepatitis vaccine.

(l) Be supervised by a registered nurse.

4221.2 After the first year of service, each PCA shall complete at least twelve (12) hours of continuing education or in-service training annually. The in-service training may be furnished while the PCA is furnishing care to the recipient under the supervision of a registered nurse.

4222 PROGRAM SERVICES: PERSONAL CARE AIDE SERVICES

4222.1 Personal care aide services shall be prescribed by a physician or Advanced Practice Nurse in accordance with the recipient's plan of treatment.

4222.2 The physician's plan of care shall be developed initially, and the plan of care shall be re-certified by the physician or Advanced Practice Nurse every six (6) months thereafter. The plan must be signed by the physician or Advanced Practice Nurse within thirty (30) days of its prescription.

4222.3 Personal care aide services shall be initiated no later than forty-eight (48) hours after completion of the initial assessment unless the recipient or the recipient's representative agree to a later date to begin the services.

4222.4 A waiver recipient may choose an individual or family member other than a spouse, or parent of a minor recipient or other legally responsible relative to provide personal care services. Each family member providing personal care services shall meet the requirements set forth in § 4221 of this chapter.

4222.5 Personal care services include, but are not limited to, the following:

(a) Basic personal care including bathing, grooming, assistance with toileting, or bed pan use;

(b) Changing urinary drainage bags;

(c) Assisting recipients with range of motion exercises;

(d) Assisting recipients with self-administered medications. The aide may remind the recipient to take the medication but cannot administer the medication to the recipient;

(e) Reading and recording temperature, pulse, and respiration;

(f) Observing and documenting the recipient's status and verbally reporting to the registered nurse or the case manager the findings immediately for emergency situations and within four (4) hours for other situations;

(g) Meal preparation in accordance with dietary guidelines and assistance with eating or feeding;

(h) Tasks related to keeping the recipient's living areas in a condition that promotes the recipient's health, and comfort, and safety;

(i) Accompanying the recipient to medically-related appointments or place of employment;

(j) Providing assistance at the recipient's place of employment;

(k) Shopping for items related to promoting the recipient's nutritional status and other health needs;

(l) Recording and reporting to the supervisory health professional and case manager any changes in the recipient's physical condition, behavior, or appearance;

(m) Infection control; and

(n) Accompanying the recipient to approved recreational activities.

4222.6 Personal care aide services shall not include services that require the skills of a licensed professional, such as catheter insertion, procedures requiring the use of sterile techniques, and administration of medication.

4222.7 Personal care aide services shall not include tasks usually performed by chore workers, such as cleaning of areas not occupied by the recipient, laundry for family members, and shopping for items not used by the recipient.

4222.8 Personal care aide services shall be provided in the recipient's place of residence or other location such as the recipient's place of employment or assistance while in transit and shall be made available seven (7) days per week.

4222.9 Personal care aide services shall not be provided in a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease.

4222.10 When a recipient is receiving PCA services and homemaker services from two different staff persons who are employees of the same agency, all supervisory registered nurse (RN) visits shall be coordinated so that supervisory in-home RN visits are made in accordance with waiver standards and the supervisory in-home RN visits are made by the same supervising RN at the same time.

4223 ADMINISTRATION AND STAFFING FOR PERSONAL CARE AIDE SERVICES

4223.1 Each provider of personal care aide services shall have a current organizational chart that clearly defines the organizational structure, staff responsibilities, and lines of authority.

4223.2 Each provider of personal care aide services shall have available to all staff and subcontractors a current policy manual which sets forth all of its policies and procedures.

4223.3 Each policy manual shall include, but not be limited to, the following information:

(a) Governance of the organization;

(b) A description of the services to be provided;

(c) Policies and procedures for recipient care and recipient safety;

(d) Financial policies including the reimbursement methodology or fee schedules;

(e) Personnel policies to include personnel management, job description, employee orientation and periodic training, performance evaluations, and employee discipline and grievance procedures; and

(f) Quality assurance standards.

4223.4 Each provider of personal care aide services shall be staffed with individuals who are qualified to:

(a) Provide quality services in accordance with a recipient's ISP; and

(b) Coordinate the provision of personal care aide services with other home health services to avoid duplication of services and to ensure coordination of care.

4223.5 Each provider of personal care aide services shall employ a registered nurse who is responsible for the following:

(a) Performing the initial evaluation of the recipient and regularly re-evaluating the recipient's needs;

(b) Monitoring the quality of the personal care services on an ongoing basis;

(c) Providing on-site supervision of Personal Care Aides at least once every month;

(d) Developing and reviewing the ISP and preparing monthly progress notes and quarterly reviews;

(e) Coordinating services and informing the physician, case manager, staff, and other providers of changes in the recipient's condition and needs;

(f) Assessing the recipient's condition and the need for continued care;

(g) Counseling the recipient and the family regarding meeting nursing and related needs;

(h) Developing an assignment and reviewing the assignment with the recipient or representative and the aide; and

(i) Reviewing and updating the assignment of the aide as changes in the recipient's condition occur, but at least every six (6) months.

4223.6 A registered nurse shall initially visit each recipient within forty-eight (48) hours of initiating personal care services to monitor the quality of services and monthly thereafter, for assessment and evaluation of the recipient and update of the ISP. At a minimum, the ISP shall be updated and revised quarterly.

4223.7 The registered nurse may provide an additional supervisory visit to each recipient if the situation warrants an additional visit, such as the assignment of a new personal care aide or changes in the recipient's health status. The registered nurse shall make an in-home supervisory visit to the recipient's home at least every month (within 30 days), and documentation of the supervisory visit shall be incorporated into the clinical record.

4223.8 Each provider of personal care aide services shall discontinue personal care aide services when the services are no longer required or have been determined inadequate to meet a recipient's needs.

4223.9 Each provider of personal care aide services shall notify the MAA and the recipient or recipient's representative, in writing, no less than thirty (30) calendar days prior to discharge or referral. The thirty (30) day written notice shall not be required, and oral notice may be given, if the discharge or referral is the result of:

(a) A medical emergency;

(b) A physician's order to admit the recipient to an in-patient facility;

(c) A determination by the home care agency that the discharge or referral is necessary to protect the health, safety, or welfare of agency staff; or

(a) A determination by a physician that the condition that necessitated the provision of services no longer exists.

4223.10 A provider of personal care aide services shall assist a recipient in selecting a new provider, if the recipient seeks a change in providers, and cannot abandon the recipient until the new provider has been successfully obtained.

4223.11 Each provider of personal care aide services shall immediately terminate the services of a personal care aide and instruct the personal care aide to discontinue

all services to the recipient, in any case where the provider believes that the recipient's physical or mental well-being is endangered by the care or lack of care provided by the aide or that the recipient's property is at risk.

4223.12 Each provider of personal care aide services shall develop contingency staffing plans to provide coverage for each recipient in the event the assigned personal care aide cannot provide the services or is terminated.

4223.13 Each provider of personal care aide services that contracts with a personnel staffing agency for personal care aides shall be responsible for ensuring that that the personal care aides meet the requirements set forth in these rules.

4224 INSURANCE FOR PERSONAL CARE AIDE SERVICES

4224.1 Each provider of personal care aide services shall maintain the following minimum amounts of insurance coverage:

(b) Blanket malpractice insurance for all employees in the amount of at least one million dollars ($1,000,000) per incident;

(c) General liability insurance covering personal property damages, bodily injury,
libel and slander of at least one million dollars ($1,000,000) per occurrence;

(c) Product liability insurance, when applicable.

4225 SPECIFIC PROVIDER REQUIREMENTS: PERSONAL EMERGENCY RESPONSE SERVICES (PERS)

4225.1 Each PERS provider shall:

(a) Provide in-home installation of all equipment necessary to make the service fully operational (including batteries);

(b) Conduct recipient and representative instruction on usage, maintenance, and emergency protocol of the PERS;

(c) Provide equipment maintenance (both in-home and response center);

(d) Provide twenty-four (24) hours per day, seven (7) days per week response center monitoring and support;

(e) Conduct equipment testing, monitoring, and maintenance (both in-home and response center equipment);

(f) Conduct monthly service checks;

(g) Provide documentation of all services provided, recipient contacts, equipment and system checks, and equipment servicing;

(i) Make available emergency equipment repair to the recipient on a twenty-four (24) hours per day, seven (7) days per week basis; and

(i) Allow the recipient to designate respondent(s) who will respond to emergency calls. Respondents may be relatives, friends, neighbors, or medical personnel.

4225.2 A PERS will not be provided to waiver recipients who:

(a) Are unable to understand and demonstrate proper use of the system; or

(b) Live with a person who assumes responsibility for providing care (to the recipient) and the waiver recipient is not left alone for significant periods of time.

4225.3 Each provider of PERS services shall ensure that contractors are properly supervised and that the service provided is consistent with the recipient's ISP.

4225.4 A provider of PERS service shall be exempt from the requirement to comply with an annual tuberculosis (TB) test; and

4225.5 A provider of PERS service shall be licensed to do business in the state in which it is incorporated.

4226 PROGRAM SERVICES: PERS

4226.1 PERS is a system located in a recipient's home that summons assistance from a friend, relative, or an emergency services provider (police, fire department, or ambulance) and is available twenty-four (24) hours a day, seven (7) days a week.

4226.2 Each PERS system shall be comprised of three (3) basic elements:

(a) A small radio transmitter (portable help button) carried by the user;

(b) A console or receiving base connected to a user's telephone; and

(c) A response center or responder to monitor the calls.

4226.3 The PERS is composed of two (2) procedures:

(a) Installation of the service unit; and

(b) On-going monitoring of the recipient.

4226.4 The unit of service shall be one (1) unit per monthly rental.

4226.5 The PERS service shall be:

(a) Approved as part of the recipient's ISP; and

(b) Completed by personnel who are employed by the PERS service provider and approved by the recipient's case manager. A copy of the approved ISP shall be incorporated into the recipient's service record. The record shall be maintained for a period of not less than six (6) years.

4227 SPECIFIC PROVIDER REQUIREMENTS: RESPITE SERVICES

4227.1 A respite care service provider can be a home health agency or business licensed to do business in the District of Columbia.

4227.2 The home health agency or business providing respite care services to waiver recipients shall require the respite care staff to be certified as a home health aides or a personal care aides and complete twelve (12) hours of continuing education on an annual basis.

4227.3 The continuing education for respite services shall be specifically designed to increase the staff's knowledge and understanding of the recipient's needs or the target population and to improve the staff's skills at tasks performed in the provision of service(s) in accordance with applicable service standard.

4227.4 Comprehensive records identifying dates of training and topics covered shall be maintained in each employee's personnel file for a period of not less than six (6) years.

4227.5 The respite care service provider shall develop and implement an individualized in-service training plan for each staff person when performance evaluations indicate a need.

4227.6 If the recipient has a need for a respite care service provider, the case manager shall be notified immediately and shall order the service in the frequency and duration to meet the recipient's needs.

4227.7 The respite care service provider shall develop and implement an initial intake assessment that:

(a) Assesses the recipient's respite needs; and

(b) The appropriate level of caregiver required to meet the identified needs.

4227.8 A Registered Nurse (RN) who possesses the following qualifications shall conduct the initial intake assessment:

(a) Duly licensed to practice in the District of Columbia;

(b) Is employed by the personal care aide agency, home health agency, or business; and

(c) Have at least one year of experience working with the elderly and individuals with physical disabilities.

4227.9 In conducting the initial intake assessment, the RN shall also:

(a) Establish a written emergency notification plan for each recipient receiving respite care services; and

(b) Document that the emergency plan has been reviewed with the recipient or representative and the individual staff person who will provide the respite care.

4227.10 A respite caregiver shall not leave the home or place of residence of the recipient during the period of time during which respite care is being provided unless the home care agency, home health agency, or business that is responsible for providing the services replaces the caregiver prior to the caregiver removing himself or herself from the recipient's home or primary place of residence.

4227.11 Each provider of respite services shall keep all documentation related to an emergency notification plan on file with the home care agency, home health agency, or business for a period not less than six (6) years. The waiver recipient shall also receive a copy of the emergency notification plan and shall keep it at his or her home or place of residence.

4228 PROGRAM SERVICES: RESPITE SERVICES

4228.3 Respite services may cover the range of activities associated with the Personal Care Aide role or the Homemaker role.

4228.4 Respite services shall include:
(a) Basic personal care such as bathing, grooming, and assistance with toileting or bedpan use;

(b) Assistance with prescribed, self-administered medication;

(c) Meal preparation and assistance with eating;

(d) Household tasks related to keeping the recipient's living areas in a condition that promotes the recipient's health, comfort, and safety; and

(e) Accompanying the recipient to medically related appointments;

4228.5 Respite services shall not include services that require the skills of a licensed professional, including catheter insertion, procedures requiring sterile techniques, and medication administration.

4228.6 Respite services shall not include tasks usually performed by chore workers, including cleaning of areas not occupied by the recipient, cleaning laundry for family members of the recipient, and shopping for items not used by the recipient.

4228.7 A unit of service for respite care shall be one (1) to twenty-four (24) hours spent performing allowable tasks.

4228.8 The supervisory nurse shall develop the ISP for respite services, and the case manager shall approve the ISP for respite services prior to the provision of the services. The supervisory RN must conduct the supervision of the respite aide.

4228.9 Respite services are limited to a maximum of four hundred and eighty (480) hours per year. Requirements for respite services in excess of the established limits must be approved by the MAA prior to the provision of the services.

4228.10 No waiver recipient shall receive Personal Care Aide services other than those provided by the in-home respite caregiver during the period of time which respite care is provided.

4228.11 Respite services shall not be provided to recipients who have no primary caregiver that is responsible for the provision of the recipient's care on an ongoing basis.

4228.12 A waiver recipient may choose an individual or family member other than a spouse, or parent of a minor recipient or other legally responsible relative to provide respite services

4229 SPECIFIC PROVIDER REQUIREMENTS: HOMEMAKER SERVICES

4229.1 Supervisory staff employed by the provider shall develop an ISP for homemaker services, and the recipient's case manager shall approve the ISP before it is implemented.

4229.2 The homemaker provider shall document in-home visits and telephone contacts within the recipient's record at least within ninety (90) days.

4229.3 Each provider of homemaker services shall ensure that each homemaker staff obtains twelve (12) continuing in-service education hours per year. Continuing education shall be specifically designed to increase the staff's knowledge, ability, and skills related to the tasks to be performed.

4229.4 Comprehensive records of each employee training shall be kept on file for a period of not less than six (6) years.

4229.5 In-home supervision of homemaker services shall be conducted at least once every three (3) months.

4229.6 A copy of the ISP shall be kept in the following locations:

(a) Case management provider; and

(b) Home care agency, home health agency, or business.

4229.7 A waiver recipient may choose an individual or family member other than a spouse, or parent of a minor recipient or other legally responsible relative to provide homemaker services.

4229.8 Each person providing homemaker services shall complete a 75-hour initial training course, hold a Home Health Aide/Homemaker certificate from a training institution approved by the District of Columbia Nursing Aide Training Program, and shall have successfully completed a competency evaluation.

4229.9 Homemaker service providers shall require twelve (12) hours of continuing education annually. Continuing education shall be specifically designed to increase the staff's knowledge and understanding of the targeted population and to improve staff skills at tasks performed in the provision of homemaker service(s) in accordance with general and each applicable service standards.

4229.10 Homemaker service providers shall maintain comprehensive records in each employee's personnel file for a period of not less than six (6) years identifying dates of training and topics covered.

4229.11 Homemaker service providers shall develop and implement an individualized in-service training plan for each homemaker staff when performance evaluations indicate a need.

4229.12 Homemaker staff shall successfully complete initial cardiopulmonary resuscitation ("CPR") training and annual re-certification. Homemaker staff shall complete the initial CPR training prior to the provision of homemaker services.

4229.13 Each home care agency, home health agency, or business providing homemaker services shall conduct supervision of the homemaker by the supervisory RN at least on a quarterly basis.

4229.14 When a recipient is receiving homemaker services and Personal Care Aide (PCA) services from two different staff persons who are employees of the same agency, all supervisory Registered Nurse (RN) visits shall be coordinated so that supervisory in-home RN visits are made in accordance with waiver standards and the supervisory in-home RN visits are made by the same supervising RN at the same time.

4230 PROGRAM SERVICES: HOMEMAKER SERVICES

4230.1 Homemaker staff shall meet established standards of education and training as approved by the District of Columbia for the provision of homemaker services.

4230.2 Homemaker services shall only be provided in cases where neither the individual nor anyone else in the household is able to provide the service or pay for the provision of the service. Payment will not be made to a provider who is the waiver recipient's spouse, parent of a minor or, other legally responsible relative.

4230.3 Homemaker staff shall perform the following tasks when providing homemaker services:

(a) Grocery shopping;

(b) Meal preparation;

(c) General household cleaning such as:

(1) Cleaning bathrooms;

(2) Vacuuming;

(3) Dusting;

(4) Mopping floors;

(5) Sweeping floors;

(6) Bed making;

(7) Linen changing;

(8) Wiping appliances; and

(9) Washing and ironing clothes.

(c) Running errands for recipients that are necessary to maintain the recipient in the home (for example, picking up medicine or mailing payments for utilities); and

(d) Providing escort services to and from medical appointments.

4230.4 A unit of service for homemaker services is one (1) hour spent performing the allowable task(s).

4231 SPECIFIC PROVIDER REQUIREMENTS: CHORE AIDE SERVICES

4231.1 A home care, home health agency, or business providing chore aide services shall:

(a) Require that all persons providing chore services successfully complete a Homemaker or Health Aides Training and Certification Program. The training shall meet all the requirements of the D.C. Department of Health, Health Regulations Administration governing home health aides;

(b) Require that chore aides complete a minimum of six (6) hours of continuing education on an annual basis. Initial training must be completed before a chore aide is assigned to a recipient's home;

(c) Require continuing education for chore aide services that shall be specifically designed to increase the staff's knowledge and understanding of the population served and to improve the skill level of the staff regarding the tasks performed in the provision of service(s) in accordance with general service standards and each applicable service rule; and

(d) Maintain comprehensive records identifying dates of training and topics covered in each employee's personnel file for a period of not less than six (6) years. An individualized in-service training plan shall be developed and implemented for each staff person when performance evaluations indicate a need.

4231.2 A chore aide service provider shall provide a pre- and post-cleaning inspection of the home or place of residence with documentation indicating that the home environment has been placed in a state of readiness for ongoing, routine housekeeping.

4231.3 In the case of rental property and residential facilities, the case manager shall examine the existing responsibilities of the landlord or homeowner, pursuant to the lease agreement (or other applicable laws and regulations) prior to authorization of chore aide services. The case manager shall ensure that the requisite documents have been reviewed prior to ordering chore aide services on the ISP.

4231.4 Each home care, home health agency, or business providing chore aide services shall ensure that appropriate supervision of chore staff is conducted by an individual identified as one who is:

(a) Trained to evaluate the activities of chore staff personnel;

(b) Has at least two (2) years of experience supervising chore staff activities; and

(c) Has been provided with training in basic supervision by the home care, home health agency, or business.

4232 PROGRAM SERVICES: CHORE AIDE SERVICES

4232.1 A unit of service for chore aide services shall be one (1) hour spent performing allowable task(s). The maximum amount of service permitted under the waiver is thirty-two (32) units (four days). Service is limited to one (1) occurrence per recipient. An occurrence is any number of units between one (1) and thirty-two (32) units. The MAA may grant or deny exceptions to the number of units allowed for a waiver recipient.

4232.2 A waiver recipient may choose an individual or family member other than a spouse, or parent of a minor recipient or other legally responsible relative to provide chore aide services.

4232.3 Allowable tasks for chore aide services shall be the following:

(a) Washing floors;

(b) Washing windows and walls;

(c) Tacking down loose rugs and tiles;

(d) Moving items or furniture in order to provide safe access and egress;

(e) Trash removal;

(f) Removal of animal waste; and

(g) Any other activity designed to bring the environment up to a maintenance level so that it can be maintained by ongoing and regular housekeeping.

4232.4 Prohibited tasks for chore aide service shall be the following:

(a) Hands-on care;
(b) Cooking;

(c) Grocery shopping; and

(d) Respite services.

4233 SPECIFIC PROVIDER REQUIREMENTTS: EAA/HAIP

4233.1 The case manager shall ensure that a home assessment is conducted by a licensed physician or a licensed physical therapist prior to ordering EAA service(s) on the ISP.

4233.2 No EAA services shall be approved or reimbursed for a recipient who qualifies for the Handicap Accessibility Improvement Program (HAIP) administered by the District of Columbia Department of Housing and Community Development.

4233.3 The case management service provider shall assist all eligible recipients in gaining access to the Handicap Accessibility Improvement Program (HAIP) prior to including EAA/HAIP service in the ISP and shall provide documentation thereof to the MAA.

4233.4 All necessary service(s) that exceed the maximum allowable costs provided by the District of Columbia Department of Housing and Community Development shall be subject to prior authorization by the MAA.

4235.5 For rental property or leased property, no EAA services shall be approved or reimbursed unless the rental or lease agreement and all other relevant documents are thoroughly examined by the case manager to determine whether the services are prohibited or allowed with conditions.

4233.6 In the case of rental property or leased property, no EAA services shall be approved or reimbursed unless:

(a) The rental or lease agreement is thoroughly examined to determine that the services are not the responsibility of the property owner or manager; and

(b) A signed release was obtained from the management of the property.

4233.7 In the case of other residential facilities, no EAA services shall be approved or reimbursed unless:

(a) The laws, rules, regulations, and agreements are thoroughly examined to determine whether the responsibility for the services(s) is not the responsibility of the owner and/or manager of the residential facility; and

(b) A signed release from the owner and/or management of the property is obtained.

4233.8 EAA service providers shall be exempt from the annual tuberculosis (TB) testing requirements.

4233.9 Prior to initiating EAA services, the case manager shall obtain an evaluation from a Construction Analyst or Housing Inspector. The evaluation must substantiate that the home is in a condition that is structurally sound to accommodate each ordered service(s) and include any stipulation(s) or recommendation(s) on how the service(s) should be implemented.

4233.10 After receiving the evaluation by the Construction Analyst or Housing Inspector, the case manager must secure three bids (from among licensed contractors with valid provider agreements with the District of Columbia MAA) for necessary services that have been approved by MAA. Each bid submitted, in order to be considered acceptable, shall comply with each stipulation, limitation, or recommendation made by the Construction Analyst or Housing Inspector.

4233.11 Each building contractor licensed to conduct business in the District of Columbia shall ensure that all construction staff has the training and skill level required to make the allowable in-home modifications.

4233.12 The case management service and EAA providers shall maintain a copy of the waiver recipient's ISP for a period not less than six (6) years.

4234 PROGRAM SERVICES: ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS (EAA)

4234.1 Allowable in-home modifications for EAA services include the following:

(a) Installation of ramps and stair climbers;

(b) Widening of doorways;

(c) Installation of small wooden ramps as necessary to allow safe entrance and exit from a primary residence;

(d) Modifications of bathroom facilities to accommodate safe use by the recipient; and

(e) Installation of specialized electric and plumbing systems necessary to accommodate medical equipment and supplies.

4234.2 A unit of service and the maximum unit rate for in-home EAA services shall be the following:

(a) Unit A: Stair Climber	$2,000.00;
(b) Unit B: Porch Lift	$3,000.00;
(c) Unit C: Bathroom Modifications	$2,000.00; and
(d) Unit D: Small Ramp (wooden)	$90.00 per linear foot.

The maximum allowable lifetime cost per recipient is ten thousand dollars ($10,000.00) for EAA services..

4234.3 Modifications or improvements to the home which are of general utility, having no direct medical or remedial benefit to the recipient, shall not be allowable modifications for waiver services. Examples of disallowed EAA modifications are the following: carpeting; roof repair; and installation of central air conditioning.

4234.4 In-home modifications adding to the total square footage of the home shall be excluded from this benefit.

4235 INCIDENTS AND COMPLAINTS

4235.1 Each provider of waiver services shall document, report, investigate, and resolve all incidents and complaints. Each provider of waiver services shall forward a copy of each incident report or complaint to the MAA and shall maintain a copy of all incidents and complaints on file for a period of not less than six (6) years.

4236 AUDITS AND REVIEWS

4236.1 The MAA shall perform ongoing audits to ensure that the provider's services for which Medicaid payments are made are consistent with efficiency, economy, quality of care, and made in accordance with federal and District rules governing Medicaid.

4236.2 The audit process shall be routinely conducted by MAA to determine, by statistically valid scientific sampling, the appropriateness of services rendered

and billed to Medicaid and that services were only rendered to Medicaid-eligible individuals.

4236.3 Each provider of waiver services shall allow access, during an on-site audit or review (announced or unannounced) by MAA, other District of Columbia government officials, and representatives of the United States Department of Health and Human Services, to relevant records and program documentation.

4236.4 The failure of a provider to timely release or to grant access to program documents and records to the MAA auditors, after reasonable notice by MAA to the provider to produce the same, shall constitute grounds to terminate the provider agreement.

4236.5 If MAA denies a claim, MAA shall recoup, by the most expeditious means available, those monies erroneously paid to the provider for denied claims, following the period of Administrative Review set forth in § 4237.5 of this chapter.

4236.6 The recoupment amounts for denied claims shall be determined by the following formula: A fraction will be calculated with the numerator consisting of the number of denied paid claims resulting from the audited sample. The denominator shall be the total number of paid claims from the audit sample. This fraction will be multiplied by the total dollars paid by MAA to the provider during the audit period to determine the amount recouped. For example, if a provider received Medicaid reimbursement of ten thousand dollars ($10,000) during the audit period, and during a review of the claims from the audited sample, it was determined that ten (10) claims out of one hundred (100) claims are denied, then ten percent (10%) of the amount reimbursed by Medicaid during the audit period, or one thousand dollars ($1000), would be recouped.

4236.7 The MAA shall issue a Notice of Recoupment (NR), which sets forth the reasons for the recoupment, including the specific reference to the particular sections of the statute, rules, or Provider agreement, the amount to be recouped, and the procedures for requesting an administrative review.

4237 APPEAL RIGHTS FOR PROVIDERS AGAINST WHOM A RECOUPMENT IS MADE

4237.1 The provider shall have sixty (60) days from the date of the Notice of Recoupment (NR) to request, in writing, an Administrative Review of the NR. The request for administrative review shall be submitted to the Chief, Office of Program Integrity, Medical Assistance Administration, D.C. Department of Health.

4237.2 The written request for Administrative Review shall include a specific description of the item to be reviewed, the reason for the request for review, the relief requested, and documentation in support of the relief requested.

4237.3 The MAA shall mail a written determination relative to the Administrative Review to the provider no later than one hundred and twenty (120) days from the date of the written request for Administrative Review.

4237.4 Filing an appeal with the Board of Appeals and Review shall not stay any action to recover any overpayment to the provider. The provider shall be liable to the Medicaid Program for any overpayments as set forth in the Medicaid Program determination.

4237.5 Payments otherwise authorized to be made to a provider under the District of Columbia Medicaid Program may be suspended, in whole or in part, by MAA to recover or aid in the recovery of overpayments that have been made to the provider.

4237.6 The MAA shall notify the provider of its intention to suspend payments, in whole or in part, and the reasons for making the suspension. The notice to providers shall include the following:

(a) The factual basis for the determination of overpayments including the dollar value of the overpayment;

(b) How the overpayment was computed; and

(c) Specific reference to the section of the statute, rule, provider's manual, or provider agreement that is the basis for the recoupment.

4237.7 Any provider that disagrees with the reason for a recoupment or the amount of the recoupment shall have sixty (60) days from the date of the Notice of Recoupment to submit a written request for Administrative Review to the Chief, Office of Program Integrity, Medical Assistance Administration, D.C. Department of Health.

4237.8 The written request for Administrative Review shall include a specific description of the item to be reviewed, the reason for the request for review, the relief requested, and documentation in support of the relief requested.

4237.9 Within forty-five (45) days of receipt of the Medicaid Program's written determination, the provider may appeal the written determination by filing a written Notice of Appeal with the Board of Appeals and Review, 441 4th Street, NW, Suite 540, Washington, D.C. 20001.

4299 DEFINITIONS: WAIVER SERVICES

4299.1 When use in this chapter, the following terms shall have the meaning ascribed:

Activities of Daily Living (ADL) - activities of daily living means certain functions for which an individual is evaluated by a multidisciplinary team to determine the level of help required by the individual in performance of each function, to include:

(a) Eating, nutritional planning, and preparation of meals, including special diets when prescribed;
(b) Mobility, including transferring to a bed or chair or moving about the indoors or outdoors;

(c) Getting dressed or changing clothes;

(d) Completing bathing; and

(e) Toileting, including bladder or bowel requirements, or both, such as assistance with bedpan routines, diaper care, routines to achieve or maintain continence.

Advanced Practice Registered Nurse – a person who is licensed or authorized to practice as an advanced practice registered nurse pursuant to the District of Columbia Health Occupations Revisions Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code § 3-1201 *et seq.*).

Case Management Agency – an agency under contract with the Medical Assistance Administration (MAA) to provide case management services to waiver recipients.

Case Management Services – services that assist an applicant or recipient in gaining access to Medicaid waiver services and Medicaid State Plan services.

Case Manager – a staff person from the case management agency who performs case management services.

Chore Aide – one-time non-medical, non-continuous household remediation tasks intended to place the home environment in a clean, sanitary, and safe condition, and to prepare the home environment for ongoing routine home care services.

Communicable Disease – as defined in D.C. Official Code § 7-132 and 22 DCMR § 201 of the District of Columbia Public Health and Medicine Regulations.

Emergency Situation – any urgent condition perceived as requiring immediate medical or significant intervention or one in which the perceived behavior poses a risk or danger to oneself or others.

Environmental Accessibility Adaptation (EAA) – physical adaptations to the home that are necessary to ensure the health, welfare, and safety of the individual, or that enable the individual

to function with greater independence in the home, and without which, the individual would require institutionalization.

Handicap Accessibility Improvement Program (HAIP) – a program offered by the D.C. Department of Housing and Community Development, Residential and Community Services Division, that offers assistance to low income disabled individuals who need to improve accessibility and remove barriers restricting mobility within their homes.

Family – any person related to the recipient by blood, marriage, or adoption.

Home- and Community-Based Services (HCBS) - the entire range of supportive services that help the elderly or persons with physical disabilities live independently in their homes and communities.

Home and Community-Based Waiver- known as the 1915(c) waiver under the Social Security Act that allows a state Medicaid Program to offer to beneficiaries at risk of institutionalization in a nursing facility or facility for the mentally retarded a number of services that would otherwise not be covered with federal matching funds.

Home Health Agency - an agency, organization, or distinct part thereof, other than a hospice, that provides, either directly or through a contractual arrangement, a program of health care, habilitative or rehabilitative therapy, personal care services, homemaker services, chore services, or other supportive services to sick or disabled individuals living at home or in a community residence facility. The term "home health agency" shall not be construed to require the regulation and licensure of non-medical services delivered by or through a religious organization on a small-scale, volunteer basis.

Homemaker – services consisting of general household activities (meal preparation, and routine household care) when the individual regularly responsible for these activities is temporarily absent, unable to manage the home, or care for himself/herself.

Individualized Service Plan (ISP) - a plan of action formalized with the recipient/representative and one or more health care professionals based upon the nature of the recipient's illness and identified needs. The plan includes the recipient's health care and supportive needs, and the approaches recommended for meeting those needs. Modifications are made to the plan, as required, to ensure the optimal outcomes for the recipient.

Instrumental Activities of Daily Living (IADL) – certain functions for which an individual is evaluated by a multidisciplinary team in terms of the level of help required by the individual in performance of each function.

Medicaid - a federal-state program established by Title XIX of the Social Security Act, which provides payment of medical expenses for eligible persons who meet income and/or other criteria.

Medical Assistance Administration (MAA) - the Administration within the District of Columbia Department of Health responsible for administering all Medicaid services under Title XIX (Medicaid) for eligible participants, including the Medicaid Managed Care Program and oversight of its managed care contractors.

Personal Care Aide – a person who has successfully completed the state or District of Columbia established training program and meets the competency evaluation requirements. Tasks include assistance with activities of daily living and instrumental activities of daily living.

Personal Care Aide Services – services involving assistance with one or more activities of daily living that is rendered by a qualified personal care aide under the supervision of a registered nurse.

Personal Emergency Response System (PERS) - an electronic system that enables an individual to secure help in an emergency from a friend, relative, or an emergency service provider (police, fire department, or ambulance). PERS services are limited to those recipients who live alone or are alone for significant parts of the day and who have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

Physician – a person who is licensed or authorized to practice medicine pursuant to the District of Columbia Health Occupations Revisions Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code, § 3-1201 *et seq.*).

Provider – any entity that meets the waiver service requirements, has signed an agreement with MAA to provide those services, and is enrolled by MAA to provide services to waiver recipients.

Purified Protein Derivative (PPD) – a tuberculin solution that is used in skin tests for tuberculosis.

Registered Nurse – a person who is licensed or authorized to practice registered nursing pursuant to the District of Columbia Health Occupations Revisions Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code, § 3-1201 *et seq.).*

Respite – services that include the provision of companionship, supervision, or assistance with activities of daily living and instrumental activities of daily living for waiver recipients in their home or temporary place of residence in the temporary absence of the primary caregiver. Respite services may also be provided in a Medicaid certified nursing facility or a group home.

Comments on the proposed rules shall be submitted in writing to Wanda R. Tucker, Interim Senior Deputy Director, Medical Assistance Administration, Department of Health, 825 North Capitol Street, N.E., 5th Floor, Washington, D.C. 20002, within thirty (30) days from the date of publication of this notice in the *D.C. Register*. Copies of the proposed rules corresponding to the Medicaid waiver may be obtained from the same address.

STATE EDUCATION OFFICE OF THE DISTRICT OF COLUMBIA

NOTICE OF FINAL RULEMAKING

The State Education Office, pursuant to the authority set forth in the District of Columbia Nonresident Tuition Act, approved September 8, 1960 (74 Stat. 853, D.C. Official Code, § 38-301 *et seq.*), and the State Education Office Establishment Act of 2000, effective October 21, 2000 (D.C. Law 13-176; D.C. Official Code § 38-2601 *et seq.*), hereby gives notice of its adoption of the following amendments to Section 2008 of Title 5 of the District of Columbia Municipal Regulations (DCMR) that establish new tuition rates for non-resident students attending public and public charter schools in the District of Columbia. Notice of proposed rulemaking was published in the *D.C. Register* on Friday, August 8, 2003 at 50 DCR 6460. Final action to adopt these rules was taken on October 10, 2003. The final rules will become effective upon publication of this notice in the Register.

5 DCMR § 2008.13 is amended to read as follows:

2008.13 The following shall be the non-resident tuition rates currently in effect for public and charter schools in the District of Columbia:

SCHEDULE OF 2003-04 NON-RESIDENT TUITION RATES

The rates displayed in the charts below are the same as the per-pupil allocations provided by the Uniform Per Student Funding Formula during the FY 2003 school year. Based on these rates, the tuition cost for each student who is not a resident of the District of Columbia and who is enrolled in the District of Columbia Public Schools or in a public charter school in the District of Columbia shall be calculated in the following manner:

(a) Using the Grade Level Table below, determine the rate for the grade level or span at which the student, based on grade assignment or age, will be enrolled.

Rates by Grade Level or Applicable Grade Range

Grade Levels	**Yearly Rate**	**Half-Yearly Rate**	**Daily Rate**
Pre-School/Pre-Kindergarten	$7,510	$3,755	$42
Grades K-3 (Includes students enrolled in Upgraded elementary school programs.)	$6,611	$3,306	$37
Grades 4-5	$6,419	$3,209	$36
Grades 6-8 (Includes students enrolled in Upgraded middle or junior high school programs.)	$6,611	$3,306	$37
Grades 9-12 (Includes students enrolled in Upgraded senior high school programs.)	$7,510	$3,755	$42
Alternative school, all grade levels	$8,344	$4,172	$46
Special Education Schools	$7,510	$3,755	$42
Adult	$4,814	$2,407	$27

(b) If the student is enrolled in a daytime special education program, use the table below to determine the rates for services the student will receive. Add this amount to the grade level cost in paragraph (a) of this section.

Rates for Special Needs Students Enrolled in a Daytime Special Education Program

Level/Program	Yearly Rate	Half-Yearly Rate	Daily Rate
Level 1 Special Education	$3,530	$1,765	$20
Level 2 Special Education	$5,456	$2,728	$30
Level 3 Special Education	$9,628	$4,814	$53
Level 4 Special Education	$17,330	$8,665	$96
LEP/NEP Services to Limited- and Non-English Proficient Students	$2,567	$1,284	$14

(c) If the student is enrolled in a residential school that serves special needs students, use the table below to determine the rates for any of the listed services that the student will receive. Add these amounts to the totals from paragraphs (a) and (b).

Rates for Special Needs Students Enrolled in a Residential School

Level/Program	Yearly Rate	Half-Yearly Rate	Daily Rate
Level 1 Special Education (Add-on rates for After hours Special Education Services)	$2,401	$1,200	$13
Level 2 Special Education (Add-on rates for After hours Special Education Services)	$8,729	$4,365	$48
Level 3 Special Education (Add-on rates for After hours Special Education Services)	$18,877	$9,438	$105
Level 4 Special Education (Add-on rates for After hours Special Education Services)	$18,768	$9,384	$104
Level 5 Special Education (Residential 24-hour Intensity special education school. Includes Both daytime and after hours services.)	$60,334	$30,167	$335
LEP/NEP Services to Limited- and Non-English Proficient Students (Add-on rate for after hour services)	$4,365	$2,182	$24

(d) Any student enrolled in a residential school, whether or not the student has special needs, is entitled to the Residential Rate listed below, which covers the cost of room and board. Add this amount to the total of (a), (b), and (c) above. This amount is the student's total non-resident tuition rate for the regular school year program.

Rates for Room and Board for students Enrolled in a Residential School

Program	Yearly Rate	Half-Yearly Rate	Daily Rate
Residential (Room and Board)	$10,911	$5,456	$61

(e) A non-resident student who wishes to attend summer school in the District of Columbia must register for the summer program separately from the regular school year program. Students will be admitted on a space-available basis. The non-resident tuition rates for summer school are displayed below.

Additional Rates for Non-Resident Students Enrolled in Summer School

Program	Rate
Summer School	$1,091

The rates in this schedule only apply to non-resident students enrolled in the regular school program of the District of Columbia Public Schools or a public charter school in the District of Columbia. Some schools may offer services that are not considered part of the regular school program, and participation in such programs may require payment of additional fees.